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there's a series of action steps related to that.
Q. What are some of those action steps?
A. Things like helping to fund or promote electronic medical records, helping to -- I'm trying to think of what other kinds of things we're doing. You know, trying to change some of our payment systems to reward more on quality and outcomes, not just on, you know, volume, you know, things like that.
Q. Does the transformation initiative include examining reimbursement methodologies at all?
A. I think so.
Q. What aspects of reimbursement methodologies are under study as part of the transformation issue?
A. I'm not aware of the entire breadth of it. The part that I've heard about, like reimbursement to physicians in terms of like office visits.
Q. Do you know what specifically is being considered in terms of office visits?

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A. All provider groups -- instead of -- you know, right now we reimburse for, you know, how many people do you see? Every time you see somebody you get X amount of dollars depending on how you code. It would be moving a certain part of your payment based on the clinical outcome. So you get paid for seeing people, but you would also get additional monies if you met certain clinical targets like all your diabetics were getting eye exams, you know, foot exams, whatever things that have been proven by the literature to improve health outcomes. So we're looking at how could we align methodology to people thinking more about health outcomes.
Q. What methodologies are under consideration?
A. More looking at all kinds of physician, you know, incentives and they're looking at bridges to excellence, you know, that GE puts out. That's something we should be funding. You know, we've given some money to the IH an institute of healthcare improvement, to their hospital

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initiatives. It's sort of broad based -- the American College of, you know, Physicians. I mean, they've been looking at recertification. Should we be adding some sort of funding or extra bonus point force doing that, that kind of stuff.
Q. How would a change of reimbursement methodologies impact any of those goals?
A. Because it would encourage people to maybe try to work to achieve them. All right. Let's put it this way: It wouldn't discourage them, you know, if you gave someone a bonus for, you know, getting bridges to excellence certification in diabetes, you could maybe pay them extra monies because they had achieved that, because hopefully they would be taking better care of their diabetic patients.
Q. Well, when I ask about reimbursement methodologies I'm referring specifically to the formula used in determining the amount of reimbursement. In other words, for drugs, 95 percent of AWP, for services and fee schedule amounts does the transformation initiative include

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an analysis of whether or not changes should be made to those reimbursement methodologies?
MR. COCO: Objection.
A. I don't know.
Q. Now, earlier in the day I asked you whether a change in the methodology moving to an ASP methodology would or would not impact physicians' willingness to be part of the network. Do you recall those questions?
A. Yes, I do.
Q. I believe your answer was that BC/BS is sufficiently large that they would probably contract anyway; is that correct?
MR. COCO: Objection.
A. To the extent that -- that's not quite what I said. I think what I said was I think that in terms of AS -- in terms of ASP pricing, that we didn't -- we weren't considering doing it or not doing that because we were afraid that people wouldn't contract with us. That's what I meant in that context.
Q. In other words, people would contract

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regardless of whether or not a move was made; is that what you were saying?
MR. COCO: Objection.
A. Well, I mean, that's speculation in terms -- and I can't speculate to that extent, but -- and that's sort of taken out of context of what we were talking about.
Q. Well, let me pose the question to you then.
A. Okay.
Q. If BC/BS were to change its reimbursement methodology and lower the actual amount you were paying in reimbursement, would that affect providers' willingness to enter into contracts with BC/BS of Massachusetts?
MR. COCO: Objection.
A. You know, I mean, that's a difficult question to answer. I think reimbursement's important, but we also have a fair amount of market share in this state. And so I think that, you know, people a lot of times will -- that isn't the only reason people would choose to or not to

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contract with us.
Q. If one were to suggest to you that in the health plan provider or contracting dynamic all of the leverage lies with the provider rather than with Blue Cross/Blue Shield of Massachusetts, would you agree or disagree with that statement?
MR. COCO: Objection.
A. In my opinion, I would disagree.
Q. Are you aware that's one of the positions that's been put forward by plaintiffs' expert in this case?
MR. COCO: Objection.
A. I'm not aware.
Q. Would it be fair to say that in Massachusetts Blue Cross/Blue Shield of Massachusetts has relatively strong leverage when negotiating or contracting with providers?
MR. COCO: Objection.
A. In my opinion, I think it varies.
Q. Okay. What are some of the factors that effect relative leverage?
MR. COCO: Objection.

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A. You mean in terms of or how much business position we would have with a certain group?
Q. No. I mean, you said leverage varies.
A. Right.
Q. So my question is: What causes it to vary?
MR. COCO: Objection.
A. You know, in things that I've experienced, maybe size of the group, location of the group, you know, percent membership in that community. I mean, there's a variety of business issues and attributes in any kind of negotiations that would affect, you know, that kind of negotiation or relationship. And I'm basically saying one size doesn't fit all.
Q. So, for example, a specialist in a rural area where BC/BS of Massachusetts has resident members and she is the only specialist in that area would have more leverage than, say, you know, one of many oncologists in the City of Boston?
MR. COCO: Objection.

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Q. Would you agree with that?
A. What I would agree with is that it's -- I would agree that that is definitely an interesting business situation. Whether or not that would affect anything is a whole other issue in terms of --
Q. Well, does it affect anything? In other words, does the relative leverage of providers result in any differences in the amounts they're reimbursed?
A. I think potentially sometimes it can.
Q. Okay. What are some of those instances?
MR. COCO: Objection.
A. I think that some of the large teaching hospitals that we feel are important to our network have -- are in a better position for negotiation than, you know, people who are not in those teaching hospitals.
Q. So will those teaching hospitals be able to negotiate higher reimbursement rates than other facilities?
MR. COCO: Objection.

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A. Well, I don't actually do the contracting. I don't actually do the dollars, so I would tell you that I don't know that for sure. I would tell you philosophically from what I've heard and from my perspective is that people -- we have one fee schedule and that people who have get paid more. It's based on performance of other kinds of guarantees or other kinds of additional value brought to a relationship.
Q. However, when you described the use of those multipliers earlier --
A. Yes.
Q. -- correct me if I'm wrong, but I thought you divorced that from importance of that entity to the network and said that was merely a function of whether or not they implement preventive care programs?
MR. COCO: Objection.
A. Well, I mean, that -- I mean, it takes a large entity -- that's not exactly what I said. I mean, I understand -- I mean, this is a different context. You're asking me what people -- I would

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say from my perspective, what I understand about contracts, people enter a variety of contractual relationships with them. If people are getting more monies in a standardized fee schedule, you've agreed to do more services or deliver something more than somebody who has not. And sometimes that could be a strategic partner, sometimes that could be a large delivery system. I mean, it's a variety...
Q. Well, here's my question.
A. Okay.
Q. Regardless of them providing something more. Let's assume they're providing the same service as another plan. Does the mere importance of a particular facility or practice to the network result in them being able to negotiate higher reimbursement?
MR. COCO: Objection.
A. No, I don't have any direct knowledge of that.
Q. Now, in terms of physician practices, I believe you testified earlier that there is no

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variation in terms of the amounts they're reimbursed; is that correct?
MR. COCO: Objection.
A. My understanding, again, is just what I just told you is it would have to be performance-based; that it would be some sort of -- you would be in some sort of arrangement that had a performance component to it that would allow for additional funds.
Q. Well, I would like you to leave aside for the moment the multipliers that relate to participation and attainment of preventative care.
A. Okay.
Q. My question is simply in terms of the relative leverage of different plans that we've been discussing. Are some plans -- or different practices -- are different practices able to negotiate higher reimbursement rates than others?
MR. COCO: Objection.
A. I don't know because I'm not in the contract area, and I don't know what the final rates are.

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Q. Now, are you familiar with Bay State Health?
A. Bay State hospital -- there's a BayPO, IPA, a Bay Care IPA, which --
Q. Are you familiar with an entity called Bay State Health which was at one point affiliated with Blue Cross/Blue Shield of Massachusetts?
A. Do you mean -- are you talking about a provider? Are you talking about a payer?
Q. Health insurance -- a payer.
A. A payer. There was in the '90s, and that's not the right name. Bay State -- what was it? I guess it was just called Bay State, okay, yeah.
Q. What was Bay State?
A. My brief understanding, it was a healthcare plan. I think it was physician-run. I don't know who owned it or anything like that. And I believe that they merged with them in the early '90s. But, again, I'm telling you I'm not sure about this. I mean, that's kind of my recollection.

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Q. Are you aware that for a period of time Blue Cross/Blue Shield of Massachusetts acted as a Medicare carrier?
A. Medicaid or Medicare?
Q. Medicare.
A. Yes, I am.
Q. For what period of time was Blue Cross/Blue Shield of Massachusetts a Medicare carrier?
A. That, I don't know.
Q. Did you have any involvement in the carrier side of the business?
A. No, I did not.
Q. Do you know of any individuals who were involved in the carrier side of the business were still at the company?
A. And by "carrier side" you mean?
Q. Who worked on Blue Cross/Blue Shield of Massachusetts work as a Medicare carrier.
A. Okay. I don't think so. I mean, I'm sure they're still around. That was quite a few years ago before we had our managed care for

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Medicare. And I'm trying to think of who -- I know there's got to be people, but I'll be darned if I can tell you exactly who they are.
Q. Okay.
A. It's been too long ago. I can't remember.
Q. Now, are you familiar with the litigation referred to as the In Re: Managed Care litigation or the Thomas litigation?
A. I've heard briefly about the Thomas litigation.
Q. What is your understanding of the Thomas litigation?
A. I've heard of the Thomas litigation. I really don't have an understanding. The limit of my understanding is it has something to do with coding, and that's about the limit. I'm really not involved with that at all.
Q. Are you aware that that was a lawsuit brought by providers against health plans, including Blue Cross/Blue Shield of Massachusetts?
A. Maybe, yeah.

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Q. Were you involved at all in that litigation in terms of producing documents?
A. I could have been.
Q. Do you recall anything more about the substance of that case other than that it's about coding?
A. No, because no one ever really directly -- no, I've never really been directly involved in that case, as far as I know.
Q. Now, are you aware that in 1994 Blue Cross/ Blue Shield of Massachusetts paid the government $2.75 million to settle allegations that the company submitted false Medicare reports in processing Medicare claims?
MR. COCO: Objection.
A. When was that?
Q. 1994.
A. For Medicare claims?
Q. (No verbal response.)
A. No, I'm not aware of that.
Q. Is there the first time you're hearing about that?

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A. I think about Medicare claims, yes.
Q. Are you familiar with other settlements with the federal government?
A. No. What I was -- what you're hearing me kind of reflect on is we had some issues about our managed care product, Blue Care 65, initially. There were some problems with the government related to signatures on some documentation, and that's what I thought you were referring to.
Q. Now, in your dealings with providers, have you ever had any discussions directly with providers pertaining to the prices that they pay to acquire drugs?
A. No.
Q. Do you have any information regarding prices that they pay to acquire drugs?
MR. COCO: Objection.
A. I don't believe so.
Q. Okay. And, again, this is you personally?
A. Yes.
Q. What is your understanding of the

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relationship between the price at which they acquire drugs and the amounts they reimburse, if any?
MR. COCO: Objection.
A. I'm only aware of what our payment policy is. I'm not aware of what people in general are paying for their drugs.
Q. So is the answer to my question that you have no understanding or expectation as to the relationship between the price that they pay to acquire drugs and the amount that they're reimbursed for drugs?
MR. COCO: Objection.
A. Yeah.
Q. Now, let me mark a document. This will be Exhibit Cook 002.
(Exhibit Cook 002, Document Bates-numbered BCBSMA-AWP-12489 - 12492, marked for identification.)
(Discussion off the record.)
Q. Now, there are a number of e-mails on this chain. I'll draw your attention to specific

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parts of them, but please take your time to familiarize yourself and let me know when you're ready.
(Witness reviews document.)
MR. MANGI: Off the record.
(Discussion off the record.)
MR. MANGI: Okay. Back on the record.
Q. I would like to draw your attention first to the last e-mail in the chain which starts on Page 12493. Do you have that?
A. Yes.
Q. Now, this e-mail that is sent to you from vdulong@mms.org?
A. Uh-huh.
Q. Who is that?
A. That's Virginia or Ginny Dulong at the Mass. Medical Society.
Q. What is your relationship between the Mass. Medical Society and MASCO, if any?
A. I don't know what the, like, official -- I mean, if they're part of the organization or the Massachusetts Medical Society offers them support.

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Ginny at the time in 2002 was sort of like the administration liaison for MASCO. And I am not really sure who employed her, was it the Mass. Medical Society or the group employed her, but...
Q. Now I would like you to turn to -- well, first of all, her e-mail is listing a number of specific issues and seeking an update from you as to where things stand as to those issues, right?
A. Yes.
Q. I would like you the turn to No. 6, please. And the topic is "Inadequate chemo reimbursement:" And the question is, has anyone at BC/BS had a chance to review the articles that Dr. Goldstein provided about inadequate chemotherapy reimbursement? Now, who is Dr. Goldstein?
MR. COCO: I'm sorry, new question? You said my question is this, and then you asked who's Dr. Goldstein? So you just want an answer to who's Dr. Goldstein?
MR. MANGI: I thought that was the only question that I posed.

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Q. But you can answer that. Go ahead.
A. You know, I don't know -- I don't remember this e-mail, so I don't know if that -- offhand I'm thinking is that one of the oncologists? It could have been one of the oncologists -- is there a Michael Goldstein? I can't remember if that's who that is.
Q. Do you know what articles are being referred to?
A. I don't offhand. I don't remember.
Q. Do you recall the Mass. Medical Society or MASCO forwarding you articles from time to time dealing with reimbursement issues generally?
A. No. They generally didn't send articles, and I don't think if -- in this case I look at this and it looks like this was the action items off of a meeting. I wonder if he gave us articles at that meeting. I don't think -- they don't generally send articles to us.
Q. Do you have any recollection as to what these articles were addressing?
A. No, I don't, not offhand, I don't. It's

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been a long time ago.
Q. Let me ask you to turn to the previous page on the next e-mail up, which is your response to Ms. Dulong. And if you have a look at No. 6 there, "Inadequate chemo reimbursement:", your response is "We reimburse as Medicare does AWP minus 5 percent. We understand that in some situations this is very favorable to practitioners and in others it may be less advantageous. In general we feel that this process evens itself out. If this isn't the case, we would be glad to continue to discuss this with you."
Do you recall sending that e-mail?
A. No.
Q. Okay.
A. But it says it was from me, so yes.
Q. Okay. Now, what did you mean when you said you understand that in some situations it's favorable and in others it's less advantageous?
MR. COCO: Objection.
(Witness reviews document.)
A. Well, I'm assuming -- I mean, I don't

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remember writing this e-mail, but if I read it now, I assume what I'm saying is what I said that sometimes it's more favorable to others, then sometimes it's not.
Q. Well, my question is: In what respect is it favorable or not favorable?
MR. COCO: Objection.
A. I think that, you know, not everybody -- and I'm trying to remember that time, and I don't remember clearly, but not everybody gives chemotherapy in their office and that I think that people who -- there's a lot of reasons why people would choose to do that and not choose that. I think that I think at times that if you were giving a lot of medications in your office, that you might be getting some sort of volume discount. Sometimes it was more favorable to you than not because not everybody would do this practice.
Q. Okay. So you were -- withdraw that.
So your understanding was that oncologists who did administer chemo in their offices may be able to get volume discounts that

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would lower their acquisition costs for the drugs; is that correct?
MR. COCO: Objection.
A. I wouldn't tell you that was my understanding, because nobody ever exactly said that to me, but my assumption was that might have been the -- that somehow that why doesn't everybody do this, okay? So my assumption was that somehow somebody was -- something was happening to that effect maybe.
Q. And your assumption was also that the amount of the discount would vary from provider to provider depending in part on their volume of use?
MR. COCO: Objection.
A. Well, I don't think I thought about it that much, but I think what I thought was that you might if you -- I really didn't think about it that much in terms of I think I thought that if you might get something on volume if you did a lot of volume. But I didn't really think, well, you only did -- I mean, nobody ever said to me, Jan, you get X amount when you do X, Y and Z. So I

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have no idea, but I assume that somehow, because some people did it and some people didn't, that they might get something like that.
Q. Well, I'm trying to understand specifically what you mean when you refer to the fact that they may be different situations, you know, less favorable in some, more favorable in others. Were you assuming there that the acquisition cost for drugs would vary from provider to provider, meaning the rates would be more favorable for some providers and less favorable for other providers?
MR. COCO: Objection.
A. I think I was assuming pretty much what I've told you, I mean, that, you know, I think that -- I think that -- you know, pretty much what I told you, that maybe somebody -- some things if you prescribed a lot of medications, that you got a better deal. But I mean, I didn't think a whole lot more about that than that.
Q. Now, could I ask you to turn to the very first page of the exhibit, and turning now to the

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second e-mail in the chain, which is from Nancy Marotta to Colleen Fournier. Do you see that? It's on the very first page of the exhibit, the second e-mail?
A. Oh, this one here (indicating)? Bottom?
Q. This one right here (indicating).
A. Oh, this --
Q. So the top one is the one-line e-mail.
A. Okay. All right.
Q. Now, by this point in the e-mail chain you were no longer part of the chain, right?
A. It looks like that.
Q. Who is Nancy Marotta?
A. Nancy, I believe, works in provider services.
Q. And Colleen Fournier?
A. I think Colleen -- I think works in the claim area, but I'm not 100 percent sure of that.
Q. Okay. Now, if you turn to the fourth paragraph of that e-mail where it starts -- well, it reads, "If we receive a paper claim and the invoice is attached then price the drug to pay

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whichever is less AWP minus 5 percent or the amount on the invoice."
A. Are you still on the second one or...
Q. Yeah.
MR. COCO: Right here (indicating).
A. If you --
MR. COCO: Can you read that again? She was on the wrong page.
MR. MANGI: Sure.
Q. "If you receive a paper claim and the invoice is attached then price the drug to pay whichever is less AWP minus 5 percent or the amount on the invoice."
Do you see that?
MR. COCO: It's this paragraph (indicating).
A. Okay.
Q. Now, is that reflective generally of what BC/BS of Massachusetts' reimbursement policy is with regards to drugs administered in office?
MR. COCO: Objection.
A. I don't know if you would say that's in

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general. I don't know if I can say that. I think in this situation that's what they suggested that they do.
Q. Well, in general, is the reimbursement amount paid to physicians in relation to drugs administered in office 95 percent of AWP without exception, or is it, in general, 95 percent of AWP or the bill charge, whichever is less?
MR. COCO: Objection.
A. No. I think the policy is the AWP minus 5 percent. I think that what they were talking about and if I remember what the issue was on this, was about some drug that didn't have a J code yet. And those can't -- if they don't have a J code, then they have to be manually processed. I think that's what that is. I don't know. I think that's what they're talking about.
Q. Well, this e-mail was then forwarded to you --
A. Yeah.
Q. -- amongst other people, correct?
A. So it says.

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Q. Okay. Do you recall receiving this e-mail?
A. Not this particular e-mail, but I recall this discussion with MASCO.
Q. Okay. And the discussion was about drugs that do not have an assigned J code; is that correct?
A. I believe so.
Q. Okay.
(Pause.)
MR. MANGI: Let's mark another document. We'll mark this Exhibit Cook 003.
(Exhibit Cook 003, Document Bates-numbered BCBSMA-AWP-12613 - 12614, marked for identification.)
Q. Again, I'll draw your attention to a specific part of the document, but please take your time.
A. Okay.
Q. Let me know when you're ready to proceed?
A. That's okay.

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Q. Now, this is a memo to you from James Fanale; is that correct?
A. That's correct.
Q. Do you recall writing this memo?
A. No, but it looks like something I wrote.
Q. Now, I would like to draw your attention first to the second arrowed point entitled "Multiple co-pays for cancer patients undergoing chemotherapy." Do you see that?
A. Yeah.
Q. Now, it starts with "MASCO's doctors are concerned that patients may be foregoing chemotherapy in the office set because of multiple co-pays." And then the action item at the end of that paragraph is "Robert to look into BC/BS MA waiving co-pays for outpatient chemotherapy." Do you see that?
A. Yes.
Q. Do you recall that discussion with MASCO?
A. Yes, I do.
Q. What was the issue that was under

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discussion?
A. The issue under discussion, they were concerned that people -- sometimes in cancer therapy somebody would come into the office, let's say five days in a row to receive chemotherapy, something like that, and they were saying that every time they came in, that they were receiving a co-pay, and they thought that that might be -- they would have to pay a co-pay and that might be detrimental to them continuing to have chemotherapy.
Q. Well, why would their having to pay a co-pay be detrimental to their getting chemotherapy?
A. Well, their feeling was that because in a lot of cases people think that if people have to pay money, they may make a decision, say I have to pay $25. Am I going to go or not? And they were just concerned that people were having a lot of out-of-pocket expenses in regards to their chemotherapy.
Q. And what was -- well, who did MASCO

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communicate that concern to?
A. I think they communicated that concern to me and to Steve Fox and whoever else was at that meeting. Do I put the attendees of that meeting? That was at the meeting that was discussed.
Q. And why was this a concern for BC/BS of Massachusetts?
A. Do you mean why are we concerned that they were concerned about that?
Q. Uh-huh.
A. I think we looked into it because obviously we want our members to receive chemotherapy if it's necessary for them. And we were looking at was there a potentially an undue burden in the delivery system if people were having to pay a co-pay for that kind of service.
Q. Now, who is the Robert mentioned in the action item?
A. That's Robert Mandel.
Q. Do you know whether Dr. Mandel did look into waiving co-pays?

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A. Yes, I believe he did.
Q. And now it says waiving co-pays for outpatient chemotherapy. What is being referred to there? Are we talking about a physician office or are we talking about hospital outpatient?
A. I think we were talking all, we were talking all of them.
Q. So the question was whether or not to waive co-pays for chemotherapy regardless of what the site of care is?
A. Correct.
Q. And what was the outcome of that analysis?
A. I think we actually looked into it, and we found out the reason that they were being billed a co-pay was because they were being charged an office visit, and they wouldn't have been charged -- if they weren't charged an office visit, they wouldn't have been billed a co-pay. So I believe, if I'm correct in my memory, that was what it was. And I can't -- I'm trying to remember if he finally got it okayed that on a

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Level 1 visit, that -- I can't quite remember the outcome -- that we would waive the co-pay or not for chemotherapy.

I don't really quite remember how that came down, the final end, but he was looking at -- I think the thing that surprised us was no it wasn't the fact that we were requesting a co-pay for the chemotherapy itself, it was because they were charging an additional office visit they were getting the co-pay. So that was sort of a different story.

Q. But you don't know what the final conclusion was?

A. I'm trying to remember. And I can't remember if he got that waived -- if we got it waived for a Level 1 visit or not. To be honest with you, I just can't remember if it worked out or not. I know it was a lot of discussion about it.

Q. Okay. Would you turn to the next page of that document, please --

A. Yeah.

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Q. -- paragraph entitled "Pharmacy."

A. Uh-huh.

Q. The third sentence, "MASCO voiced dissatisfaction with AWP minus 5 percent for chemoRX."

A. Uh-huh.

Q. Do you recall this discussion with MASCO?

A. You know, I actually don't on that piece. I mean, I recall the rest of -- I'm trying to recall what they would have said about that.

Q. Do you know whether this is referring to a general concern, or is it specific to Zometa, which is one of the drugs discussed here.

(Witness reviews document.)

A. I can't remember. I think Zometa -- what's this one to this one? I think Zometa was one of the drugs that they had an issue with and I can't remember if it was more outside -- talking just in general or it was about Zometa and the fact -- you know, this e-mail looks like it followed this (indicating) in that time frame.

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I think we were working with them on the fact that there were drugs that would become available, and they didn't have J codes available yet and they found that very cumbersome not to have a J code available because it was a lot of manual work. And they weren't sure about that process, but I believe that was what -- I mean, I really don't remember if it was broader than that or not.

Q. What do you understand the term "chemoRx" to be?

A. Chemotherapy.

Q. So MASCO voiced dissatisfaction with AWP minus 5 percent for chemotherapy?

A. Right.

Q. Okay. Do you recall having any general discussions with MASCO about whether the AWP minus five rate was sufficient for chemotherapy specifically?

A. You know, I don't recall if we -- I'm smiling because in general everybody always thinks they're underreimbursed, okay? So I'm trying to -

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- I really don't recall the specific -- I'm sorry, guys, I don't recall a specific discussion. I don't know if they thought we should be paying AWP, what they thought. That might be my suspicion, but I don't recall the exact discussion about what the issue was about the AWP minus 5 percent.

Q. It continues, "discussed MASCO participation at P&T committee where appropriate."

A. Yeah.

Q. Do you recall that discussion?

A. Yes.

Q. What was discussed in that call?

A. What was discussed when drugs come up are, like oral agents that you can get in the outpatient setting like some of the oral antiemetics, that they wanted to have some input, and we thought that was appropriate that we would ask them, which we do, when cancer drugs come up, that we would go out to the outpatient pharmacy benefit. We sort of ask them, "What do you clinically think of this medication? Do you think

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it adds anything?", et cetera? So we do to this day ask the clinical opinion on new medications that come for outpatient formulary.
Q. Does MASCO have a formal role in the P&T process now?
A. No.
Q. Are any of the outside individuals -- you mentioned you sit on the P&T committee -- representatives of MASCO?
A. I don't believe so. I don't think we have any oncologists on the committee right now.
Q. Have there been oncologists in the committee in the past?
A. I can only speak in my tenure. In my tenure I don't believe so.
Q. The outside input that's listed in the P&T process, is that limited to the actual P&T meeting, or does that also carry over into the pharmacy executive committee stage of the process?
MR. COCO: Objection.
A. What do you mean by that?
Q. Well, we discussed earlier that the

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formulary process has a few stages, right?
A. Uh-huh.
Q. There's the P&T meeting itself --
A. Right.
Q. -- and then were the focus clinical, and then there's the pharmacy committee where there's consideration of economic impact. And you had mentioned that at the P&T meeting itself there are some outside doctors who participate, right?
A. Correct.
MR. COCO: Objection.
Q. My question is, is their participation limited to the P&T meeting, or do they also participate in the pharmacy committee meeting that follows?
MR. COCO: Objection.
A. It's a separate process. Their input, though -- you know, the minutes of the meeting are used in the second meeting, but people -- like they don't come in live person or they don't call in or anything like that.
Q. Okay. Now, going back to this document,

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under "Action Item" it says, "Steve to work with Gary Shramek and Kim Olson on AWP issue."
A. Yes.
Q. Who's the Steve there?
A. That's Steve Fox.
Q. All right.
A. And Gary Shramek was the clinical director of pharmacy at the time.
Q. Kim Olson?
A. And Kim Olson, I think by that org. chart was probably -- I think she was the director of pharmacy program -- I mean, in terms of she was the person that they all reported up to.
Q. What is the AWP issue that they were going to be working on?
A. I suppose, looking at this -- and I seriously don't remember the discussion. It was what we said above, that they were dissatisfied with the pricing for chemotherapy and I'm assuming that Gary was going to talk to Kim about that in terms of what that was.
Q. Were you involved in the follow-up?

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A. I don't remember because I don't remember this discussion, and I was -- I suspect that, you know, what we told them was we, you know, in many cases follow Medicare and this is what Medicare does and this is what we'll do, but I don't remember specifically talking to Kim about that.
Q. Okay.
MR. MANGI: Let's take a quick break. Off the record.
(Recess taken.)
Q. Are you familiar with the term "specialty pharmacy"?
A. Yes, I am.
Q. What is your understanding of what a specialty pharmacy does?
A. My understanding is that a specialty pharmacy is a pharmacy that might specialize in the delivery of certain types of drugs. And a lot of times they have kind of cool programs associated with them in terms of like waste management, member education, things like that.

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Q. Are you aware that BC/BS of Massachusetts implemented a specialty pharmacy program in the 2003/2004 time frame; is that correct?
A. I know Blue Cross/Blue Shield have a specialty pharmacy program, but I don't know when it was implemented.
Q. Let me show you a document, and we'll mark this as Exhibit Cook 004.
(Exhibit Cook 004, Document Bates-numbered BCBSMA-AWP-10592 - 10604, marked for identification.)
Q. Take a look at that document, and let me know when you're ready.
(Witness reviews document.)
Q. Again, I'll draw your attention to specific portions, but let me know when you're ready.
(Witness reviews document.)
A. Okay.
Q. Have you ever seen this document before?
A. I don't remember this specific document,

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no.
Q. Okay. Do you know when this document was generated?
A. No, I don't.
Q. Let's see if we can figure that out. If we take a look at Page 10 of the document.
A. Yeah, Page 10.
Q. You'll see that this reflects data from the period January 1st, '02 until 10/31/02?
A. Yes, I see that.
Q. So it would be fair to assume that this document was generated after that time period, right?
A. Pardon? What?
Q. It's fair to assume this document was generated after that time period since it reflects data for that time period?
MR. COCO: Objection.
A. I don't know.
Q. Well, have a look at Page 13 of the document. This is a time line. Do you see that?
A. Yes.

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Q. And the task list starts with "Establish Specialty Rx Steering Committee," and the target date there is March of 2003, right?
A. Correct.
Q. Okay. So it's fair to assume this document was generated sometime prior to that, right?
MR. COCO: Objection.
A. I don't know when it was documented because it would have been documented later, too.
Q. Well, you were on this specialty committee at Blue Cross/Blue Shield of Massachusetts, weren't you?
A. I have supported a variety of those committees, yes.
Q. When Blue Cross/Blue Shield of Massachusetts first decided to enter into specialty pharmacy relationships, it had a committee that considered what vendors to contract with and what the parameters of the program would be, correct?
MR. COCO: Objection.

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A. It has -- can you restate that one more time again?
Q. Sure. When Blue Cross/Blue Shield of Massachusetts decided to implement a specialty pharmacy program, it had a group of people or a committee that looked at the issue, decided what the parameters of the program would be and who they would contract with, right?
A. I think they had a variety of committees that looked at that topic.
Q. Is there a specific committee tasked with the specialty pharmacy implementation?
A. Implementation?
Q. Strategizing and then implementation.
MR. COCO: Objection.
A. I don't remember, but I suspect there was.
Q. Are you aware that prior witnesses have testified there was a committee and you were on it?
A. No, I'm not aware that they testified that.

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Q. Do you know what the eventual decision was in terms of what drugs would be supplied through specialty pharmacies and what drugs would not?
A. Am I aware that what drugs were to be supplied to specialty? Yes, I am.
Q. Is it correct that -- am I correct that the eventual decision that was reached was to exclude physician-administered drugs from the parameters of the specialty pharmacy program that was initially implemented?
A. I think -- I'm not -- I don't think that -- I don't know if that was exactly what the decision was made. I think the decision was made to look at -- I think it was more complex than that, and I'm not sure --
Q. Well, perhaps I can assist by rephrasing the question.
A. Yeah.
Q. Am I correct that when a specialty pharmacy was first implemented, physician-administered drugs were not subject to it?

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A. I believe so.
Q. Now, I would like you to turn to Page -- well, the Page Bates-numbered 10598. The page is entitled "Specialty Pharmacy, Categories of Injectables." Do you have that page?
A. Uh-huh.
Q. The bottom bullet says "Physician Administered Oncology Medications Examples: Chemotherapy, Antiemetics." The subbullet says "1/26 New York Times article - Physicians are able to obtain discounts as high as 86 percent on medications. Plan reimbursement to providers for medication is in the range of AWP minus 5 percent."
Do you see that?
A. Yes, I do.
Q. Now, it's fair to say since this is part of the documentation generated in considering the specialty pharmacy issue, that Blue Cross/Blue Shield of Massachusetts was aware of this at the time that it decided to exclude a specialty pharmacy -- physician- administered from the ambit

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of its specialty pharmacy program?
MR. COCO: Objection.
Q. Do you agree with that?
A. I don't know. I can't say what Blue Cross/ Blue Shield of Massachusetts was aware of.
Q. Well, this is a Blue Cross/Blue Shield of Massachusetts document, isn't it?
A. It looks like it.
MR. COCO: Objection.
Q. Assuming that it is a Blue Cross/Blue Shield of Massachusetts document since someone at the company generated it, they were aware of this information, right?
MR. COCO: Objection.
A. You know, I don't know who -- this doesn't have any of the markings of -- I don't know who generated this document, and I don't know -- I mean, you're asking me something I don't know.
Q. Okay. Let me make it easier.
A. Okay.
Q. I'll ask you to assume that this

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document has been produced by the files of Blue Cross/Blue Shield of Massachusetts, okay? Assuming that to be true, we can agree, can't we, that at the time the specialty pharmacy program was being planned, this document was generated, someone at Blue Cross/Blue Shield of Massachusetts was aware of the facts reflected in this document?
MR. COCO: Objection.
Q. We can agree about that, can't we?
MR. COCO: Objection.
A. I think somebody prepared this document. How's that? But I don't remember this specific document, and I can't say -- but if this comes from Blue Cross/Blue Shield, obviously somebody prepared this document.
Q. And I'm correct, aren't I, that the -- that physician-administered drugs were not made part of this scope of the specialty pharmacy program?
MR. COCO: Objection.
A. The specialty pharmacy program is sort of an ongoing program, and so --

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Q. To date have physician-administered drugs been suggested to the specialty pharmacy program?
A. I don't believe so.
Q. Now, turning over the next page, which is Page 8 of the document, the page entitled "Chronic Disease states and examples of some of the leading pharmaceutical treatments." And there are a number of physician- administered drugs listed here, such as Remicade. Do you see that?
A. I see Remicade.
Q. So Blue Cross/Blue Shield of Massachusetts did consider the range of physician-administered drugs that are being administered in the market, including Medicaid -- including Remicade, right?
MR. COCO: Objection.
A. I think these drugs can be -- they can be administered in more than one setting, so I wouldn't call them -- but they did consider Remicade, yes.
Q. I mean, let's stick with the example we

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have. Are you aware that Remicade is exclusively physician-administered and not a self-administered drug?
A. It's not self-administered, but it can be administered in a hospital or an outpatient, you know, clinic. It could even be potentially home infusion.
Q. And let me ask you to turn also to Page Bates numbered 10601.
A. 10601.
Q. Which is the data analysis?
A. Look like this (indicating)?
Q. Yeah. Now, this is pharmacy claims for all products. Does this reflect the relative percentages of the total drug span on specialty drugs for Blue Cross/Blue Shield of Massachusetts?
MR. COCO: Objection.
A. I don't know because I didn't produce this data.
Q. My question is, looking at this, do you know what this data is?
MR. COCO: Objection.

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A. If I look at it, I see what it says. Specialty pharmacy data analysis.
Q. Okay.
A. But I don't know if that is the total sum of all -- I don't know.
Q. Okay. Based on your own experience in dealing with providers who are in Blue Cross/Blue Shield of Massachusetts network, do you have any way of assessing whether or not these figures would accurately reflect the percentages of those?
MR. COCO: Objection.
A. I don't know.
Q. For the record, I would ask that the custodian of this document be identified.
MR. MANGI: Let's mark another document. This is going to be Exhibit Cook 005.
(Exhibit Cook 005, Document Bates-numbered BCBSMA-AWP-12679 - 12680, marked for identification.)
Q. Now, what is the specialty committee that's referred to in "Specialty Committee Meeting" in the heading?

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MR. COCO: Objection.
A. What is the specialty committee?
Q. Right.
A. You mean, what is the specialty committee meeting?
Q. Was this a -- by "specialty committee," is it a committee dealing with a particular experiment, or is it something else?
MR. COCO: Objection.
A. It's a -- this was a meeting -- the regional medical directors have meetings with various specialty groups.
Q. Okay.
A. And that is sort of like a generic term for identifying this type of meeting.
Q. Okay. And it says here that this is a follow-up to the routine spring specialty meeting?
A. Yes.
Q. So were there annual meetings with MASCO, which is the group at issue here?
MR. COCO: Objection.
A. We try to touch base and -- at least

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this was -- we try to touch base like once or twice a year to see what's going on.
Q. Now, under "Specialty Pharmacy" this minutes says, "The group does not believe specialty pharmacy, as they have experienced it, will be successful with oncology patients." And then it goes on to list certain barriers that the group perceived.
Do you see that paragraph?
A. Yes, I do.
Q. Were these some of the considerations that Blue Cross/Blue Shield of Massachusetts factored in to its decision in determining the parameters of the specialty pharmacy program?
MR. COCO: Objection.
A. I think that what the oncologists had to say was taken into account for oncology medication and what some of the things that would have to be addressed by a specialty pharmacy program in oncology.
Q. Do you recall any specific discussions at Blue Cross/Blue Shield of Massachusetts as to

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whether or not an oncology drug should be included in the specialty pharmacy program?
MR. COCO: Objection.
A. I think in the specialty pharmacy program we've talked about all kinds of medications, including oncology medications, urology medications.
Q. Why was a decision made not to include oncology physician-administered drugs within the parameters of the program?
MR. COCO: Objection.
A. Well, I don't know why the decision was made, but I can tell you what I contributed to the discussion.
Q. Okay.
A. And that would be these points that would have to have been addressed and discussed. Because these were the concerns that -- if as far as MASCO at that point in time -- if one was to do a specialty pharmacy program with them, these are the things that we would have to be able to address with a specialty pharmacy program. So

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that was one piece, I think of the decision making.
Q. Okay. So one piece of the decision was communications of concerns from MASCO and other provider oncology groups, right?
MR. COCO: Objection.
A. I think people heard their input. I don't know how much that weighed into the decision -- you know, what the weight that went into the decision not to do it at that point in time.
Q. It was one of the factors into the decision?
A. I think it was one of the factors discussed.
Q. Were there other factors that went into that decision?
MR. COCO: Objection.
A. I think one of the things that people discussed as being important would be because, as we said before, our pricing was different across the network in terms of that, you know, we talked about this methodology, the AWP minus 5 percent

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for physicians' offices, that the pricing in the hospital outpatient setting was different. And so one of the things that -- I think that was something that was discussed in terms of implementing these -- implementing specialty pharmacy programs for the physician-based medications, particularly the oncology-based medications.
Q. Well, why does that -- why was that difference relevant to the continuation of specialty pharmacies?
MR. COCO: Objection.
A. You mean, why were we discussing that?
Q. Well, my question was -- well, withdraw that.
I just asked you to describe the other factors that were involved in the decision not to include oncology drugs within the scope of this program, right?
A. Yes. Yeah.
Q. And your answer pointed to the fact that there are different reimbursements in hospital

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outpatient departments --
A. Right.
Q. -- versus physicians' offices?
A. Right.
MR. COCO: Objection.
Q. My question was, why was that difference relevant? How was it pertinent to the decision whether or not to implement -- include these drugs in the scope of the specialty pharmacy program?
MR. COCO: Objection.
A. We felt it was relevant, because if you notice on the last thing that they -- indeed that the group in the past -- that Harvard Pilgrim, one of the other payers, had put in a specialty program and it hadn't been successful. And what happened was that the care -- I'm not really sure in that case if they continued to deliver the care that -- for temporarily care was moved back into the hospital setting. But one of the things -- thoughts would be that if one was going to do specialty pharmacy, one of the things to be considered was all the site of service that

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chemotherapeutic care could be given and trying to make sure that the pricing was somewhat similar across those sites of service.
Q. So the concern was that if the program were implemented in the form that was being considered, the patients may be moved from the physician office to hospital outpatient departments?
MR. COCO: Objection.
A. I think because the group -- just relating these conversations to me, had such a negative experience in the past with specialty pharmacies, the discussion was that these issues would have to be addressed and if they would choose not to participate in those specialty pharmacy initiatives, then care would be delivered in the hospital setting. And so we wanted to make sure that the pricing in the hospital setting was going to be -- you know, would be reasonable to -- or it would be on par to have care delivered in that site.
Q. Okay. So that was another concern that

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was put forward in terms of the consideration of this issue?
MR. COCO: Objection.
A. It was another thing that was discussed.
Q. Right. Anything else?
A. I think those are -- I think the big concern was -- I think those were the big concerns that basically the group's experience in these issues, which are reasonable issues to be addressed, you know, same side of -- you know, same day administration, wastage, et cetera, and then the issue about the hospitals.
Q. Let me show you another document.
MR. MANGI: We'll mark this as Exhibit Cook 006.
(Exhibit Cook 006, Document Bates-numbered BCBSMA-AWP-10608, marked for identification.)
Q. Now, this is -- these are minutes from the provider financial strategy work group where you're listed -- actually, you're not listed as an attendee, you're discussed in the text in the

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bottom paragraph. Do you see that?
(Witness reviews document.)
A. Yes, I see that.
Q. Okay. Now, what's being discussed here is whether BC/BS of Massachusetts would follow Medicare's lead and implement the same change for BC65. What is that issue?
A. BC65 was Blue Care 65. That was our managed Medicare product. I wasn't at this meeting, so reading from this minutes it says that they would think about following Medicare -- this proposal on AWP for the Blue Care 65 products.
Q. It says here that "Deb will discuss this issue with Jan Cook" --
A. Yeah.
Q. -- "to determine if Jan has committed to a dialogue with oncologists prior to the external communication of this change."
Do you recall having that discussion with Deb?
A. No, not this -- no, not particularly.
Q. And the Deb at issue there is Deb

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Deveaux, right?
A. Yes, I believe so.
Q. Do you recall whether or not the change was implemented for the BC65 program?
A. I don't believe it was.
Q. So the reimbursement rate for the BC65 program, which is the managed Medicare program, remained at 95 percent of AWP even when Medicare moved to 85 percent of AWP; is that correct?
A. I believe so.
Q. Has it remained at that rate today?
A. The product doesn't exist anymore, so...
Q. When did the product cease to exist?
A. Good question. It recently changed, I would say, in 2005. I'm not sure of the date. The product is no longer. It's changed names, and because of Medicare Part D, you know, a lot of this has changed in terms of that.
Q. Why was the reimbursement rate not changed for BC65 product?
A. That, I don't know particularly. I mean, I don't know what the discussion they had in

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regards to that. I wasn't privy to that, why they decided not to do that.
Q. Well, one of the issues that it's saying Deb is going to talk to you about is dialogue with oncologists, right?
A. Correct.
Q. Okay. Was dialogue with oncologists part of the consideration?
MR. COCO: Objection.
A. I don't know what they discussed, because they didn't invite me to this discussion, so I don't know what they --
Q. Do you know whether or not Deb did speak to you?
A. I don't remember her -- Deb speaks to me all the time. I don't remember her speaking -- for me for this meeting, no, not particularly.
Q. Do you recall conveying any input to Deb or anyone else in the PFSW as to whether or not BC65 should or should not move from 95 to 85 percent for AWP?
A. John Fallon listed on this is my boss,

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and I surely would have said to him that -- I would have communicated the concerns expressed in this memo, but no one -- I don't believe anybody asked me specifically --
Q. Which concerns are you referring to?
A. This (indicating).
Q. Well, the concerns listed there are in relation to specialty pharmacy programs, aren't they?
A. Yeah. Okay. I would have talked to them about what my relationship -- my boss knew what my relationship was with this MASCO, what we were talking about, what we were communicating with. We did commit to them to have ongoing discussions with them in terms of informing them of anything that we were going to do prior to doing it.
Q. Well, I mean, the issue under consideration here is changing the BC65 rate from 95 to 85 percent of AWP, right?
MR. COCO: Objection.
A. I mean, that's what it says in here,

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this document.
Q. Do you recall providing -- conveying any input from MASCO oncologists as to that issue?
A. About Blue Care 65?
Q. Right.
A. No.
Q. Or about the move from 95 to 85 percent of AWP?
A. No, I don't recall that.
MR. MANGI: Let's mark another document. This is going to be Exhibit Cook 007.
(Exhibit Cook 007, Confidential document headed "Analysis of CMS Average Wholesale Price Reform Reimbursement for Part B Drugs," no Bates stamp, marked for identification.)
Q. Take a look, and let me know when you're ready to proceed.
(Witness reviews document.)
MR. NOTARGIACOMO: Just while she's reviewing it, I notice that this one wasn't Bates stamped.
MR. MANGI: Yeah this one was produced

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electronically on a CD. It was printed out without Bates numbers.
MR. NOTARGIACOMO: The CD was labeled private and confidential, correct?
MR. MANGI: I'm not sure, but I'm happy to take your word for it.
MR. SKWARA: Okay. But we would like to have this deemed confidential.
MR. MANGI: Off the record.
BY MR. MANGI:
Q. Okay. Are you familiar with this document, Dr. Cook?
A. No, I'm not.
Q. Do you have -- you have no recollection of ever having seen this before?
A. I don't recall this specific document.
Q. I'm going to ask you to turn to Page 12 of the document?
A. Which Page 12?
Q. The pages are on the right-hand side?
A. You mean the page, not the drug -- you mean the front part?

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Q. Where it says "Option 1."
A. Yeah.
Q. You'll see on that page and then the succeeding pages there are four different options that are discussed?
A. Yes.
Q. I understand that you haven't seen this document before, but do you recall discussion about these options?
A. I remember discussed -- not necessarily organized quite like this, but I remember people discussing these options.
Q. Well, Option 1 is "Move to CMS ASP with changes in Admin. Fees," right? That's at the top of the page?
A. That's what it says, yes.
Q. Now there's a listing here of cons. Is it your understanding that these are some of the factors that were weighed in deciding whether or not to adopt this option?
MR. COCO: Objection.
A. I don't know because I don't think I was

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at this meeting. I can just tell you what it says here.
Q. I'm asking you, based on the general discussions that you did have around this topic, do you recall these being issues that were discussed?
A. I think these were some of the issues that were discussed at the time.
Q. One of the issues that was discussed was a resistance to the change by network, right? And that corresponds to some of the concerns you described earlier that were voiced by MASCO, right?
MR. COCO: Objection.
A. Well, I don't know what it means because -- I don't know what it means in terms of is it just specific to MASCO or was it to other network concerns.
Q. What's your understanding of the next bullet, which is "Potential shift to facility setting (Oncologists)"?
MR. COCO: Objection.

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A. That's what you and I were discussing before that if the oncologists decided not to deliver chemotherapy in their office, that where would these folks receive chemotherapy.
Q. Do you know which of these options was implemented, which of these four options, if any?
A. I think -- I think that now -- well, I think that now we're still at Option 3, but I don't know if that was -- you know, if that was a temporary --
Q. Are you familiar with an entity called R.J. Health?
A. I may have vaguely heard of that name before.
Q. Do you know whether or not Blue Cross/Blue Shield of Massachusetts purchases AWP schedules from R.J. Health?
A. I don't know.
Q. So is the answer that you think it was Option 3, but you're not sure?
A. If you asked me what our current -- I can tell you what I think our current policy is,

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and our current policy is 3. So I don't know what the discussion at -- if this discussion, because I wasn't at this meeting, was tabled, if there was a future plan made. What I can only tell you is what today -- what's happening today.
Q. Well, are you aware that that's inconsistent with testimony from prior BC/BS witnesses who indicated that BC/BS of Massachusetts' new purchasing fee schedules that are AWP- based from R.J. Health?
MR: COCO: Objection.
A. How is that inconsistent?
Q. Well, if you look at Option 3, the option is maintaining current 95 percent off 2004 AWPs?
A. Oh, okay.
Q. And the cons are stagnant -- include stagnant drug fees, in other words, reimbursement would be frozen?
A. Then I made an error because I wasn't focusing on the 2004. What I was speaking to was that I think we're still paying 95 percent of AWP.

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On which fee schedule or what AWP listing, that I don't know.
Q. Now, looking at these options, is it fair to say that Blue Cross/Blue Shield of Massachusetts did not consider shift -- pulling Medicare to the AWP-based methodology but not also increasing administration fees? That wasn't something that was even considered, right?
MR. COCO: Objection.
A. I don't know if that was considered or not.
Q. Okay. Well, I mean, let's look at the options. Option 1 is changing the admin. fees and moving to ASP, right?
A. Right. That's what it says.
Q. Option 2 is a budget neutral change which would involve applying a multiplier to the CMS ASP fees so that the change would be budget neutral, so that there would be no change in the overall amount reimbursed. Do you see that?
A. I see that.
Q. Okay. And there would be no changes to

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the admin. fee, but the drug reimbursement would be multiplied, right? And that's at the top of the page?
MR. COCO: Objection.
A. Okay.
Q. The third option is the one we discussed which is frozen rates, right?
MR. COCO: Objection.
Q. Do you see that?
A. I see Option 3.
Q. And the fourth option is getting J codes from an outside vendor. Do you see that?
A. I see that.
MR. COCO: Objection.
Q. Okay. Now, are you aware of any options that were discussed other than these four?
MR. COCO: Objection.
MR. MANGI: What's the basis for the objection to that?
MR. COCO: She's -- first of all, lacks foundation. She's previously testified that she was not present at the meeting in which this

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document you're referring to was generated. Second, your question was, Are you aware of discussions? You have not specified discussions with who.
MR. MANGI: That's not the question.
Q. The question was, are you aware of any options other than these four that were contemplated?
MR. COCO: Excuse me, could you go back to the record to read his previous question to which I objected, please?
MR. MANGI: I'm happy to do that if you're happy to have the witness stick around after 3:50. Why don't we do it after the deposition's done.
Q. Let me rephrase the question: Are you aware of any discussion of any options other than these four you've listed here?
MR. COCO: Objection.
A. No, but I'm also not aware of all these options, either.
Q. Okay. Do you know who was responsible

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for making the ultimate decision as to whether or not to shift methodologies?
A. No, I do not.
Q. Okay.
MR. MANGI: Let's mark the next document.
(Exhibit Cook 008, Document Bates-numbered BCBSMA-AWP-12576 - 12587, marked for identification.)
Q. Now, this is a -- the cover page is an e-mail from John Killion?
MR. NOTARGIACOMO: Do you have an extra copy?
MR. MANGI: Oh, sorry.
Q. From John Killion to you dated Feb. 7 of '05.
(Witness reviews document.)
A. Okay.
Q. So you did receive this presentation from Mr. Killion on Feb. 7th, 2005, correct?
A. I don't remember receiving it.
Q. Okay. Now, I note that the date on the

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attachment to this e-mail, December 15th, 2004, which is on the attached analysis, do you see that?
A. Huh? I don't --
Q. December 15th, '04?
A. Oh, yeah, December 15th, 2004.
Q. You see that's different from the date on the version of this that we've marked as the previous exhibit?
A. Okay.
Q. That's Feb. 7th, '04, right?
A. Previous exhibit was February 7th, 2004, and this one is December 15th, 2004.
Q. Right. Do you know whether or not this analysis was ongoing throughout the period from February to December of 2004?
A. I don't know.
Q. Do you know whether discussions pertaining to this issue were ongoing throughout that period?
A. I don't directly know, no.
Q. Do you recall in what period this issue

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was being discussed?
A. I think that -- I could say that we're always talking about specialty pharmacy drugs, and I think we're always talking sort of ongoing.
Q. So the discussion was and remains ongoing as to consideration of different methodologies in light of all the information that's available?
MR. COCO: Objection.
A. I would say periodically this is discussed, specialty pharmacy's an ongoing consideration. Whether people are talking about this every day or periodically.
Q. Well, the issue there is not specialty pharmacies, the issue there is moving to an ASP-based methodology, correct?
A. I don't -- yeah, I don't know when the last time we've talked about this exactly was. I don't remember.
Q. Well, when you said it's an ongoing discussion, are you aware of that discussion continuing?

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A. Personally, no.
MR. MANGI: Let's mark Exhibit Cook 009.
(Exhibit Cook 009, Document Bates-numbered BCBSMA-AWP-12589 - 12590, marked for identification.)
Q. Take a look at that, and let me know when you're read did to proceed, please.
A. Okay.
Q. Now, do you recall this e-mail?
A. No, I don't.
Q. What's the issue that's under discussion in that e-mail?
A. The issue under discussion is the prescription drug bill that the federal government passed reimbursing physicians for drugs administered in their office.
Q. Okay. Now, the bottom e-mail is a communication from a urologist to Dr. Fallon; is that correct?
A. Correct.
Q. And the urologist is expressing concern about the change in the government's methodology

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and urging BC/BS of Massachusetts to, quote "Leave your policy as is and continue to reimburse us at the same schedule as before," right?
A. You're reading that, yes.
Q. Right. Now, when Dr. Fallon forwards this on to you, he says "yet another Sunday night e-mail." Do you see that?
A. Yeah, he's going to love that. Yes.
Q. What was he referring to when he said he had another Sunday night e-mail?
A. My boss has a wonderful sense of humor, and as you all do, he works a lot, all the time. And physicians will e-mail him seven days a week. So I think he was sharing some humor with me and saying, "Jan, I have got another e-mail here."
Q. When he says "yet another Sunday night e-mail," is he referring to the fact that it's just another e-mail he got on a Sunday, or is he referring to it being yet another communication from a physician on this topic?
MR. COCO: Objection.
A. I don't know.

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Q. Do you recall communications of this kind, other than this one?
A. No, I don't.
Q. Okay. So this is the only communication you're aware of from a physician directly to Blue Cross/Blue Shield of Massachusetts urging the company not to follow CMS moving to ASP?
MR. COCO: Objection.
A. Oh, I didn't see that.
Q. Are you aware of other communications from physicians to Blue Cross/Blue Shield of Massachusetts urging them not to move to an ASP-based methodology?
A. No, not directly, no.
Q. So this is the only communication of this kind that you've seen?
A. If you phrase it that way, yes.
Q. Okay. Are there communications dealing with this issue you're familiar with in a different form or a different format?
A. Do you mean -- are you meaning would physicians be talking to us about this issue in a

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different format, particularly?
Q. Yeah.
A. I would suspect -- I don't remember any specific communications, but people call us and talk to us on the phone, people talk to us on the street, so in general, people -- there are a lot of different ways people communicate with us. I don't remember any specific communication, specific letters or specific e-mails, but the reference is in here that -- he references in here that he saw in our newsletter that communication that we had sent out.
Q. Where were you referring to that?
A. In the second paragraph where he said -- boy, that's bad grammar -- "I read through your newsletters that you are trying to decide what to do with your own policy."
Do you see that?
Q. Now, do you recall any conversations, oral conversations or phone conversations, with physicians dealing with similar issues?
MR. COCO: Objection.

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A. The only phone conversation I recall which was striking to me was someone called me to tell me they couldn't find a drug at the ASP price in Massachusetts. A physician did. That was in the last year or so.
Q. "Couldn't find a drug at the ASP price," what do you mean by that?
A. Yes, that's exactly what they said.
Q. Well, did they mean by that they couldn't find what the ASP was, or did they mean that they couldn't find a drug available for purchase at that rate?
A. My assumption was what you just said, the latter.
Q. Okay. So the physician was saying that they could not purchase the drug at the ASP rate?
A. That's correct.
Q. What was your response to that?
A. We don't use ASP. We pay AWP minus 5 percent.
Q. Okay. Who was that communication from?
A. It was a physician that called me, and I

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don't remember his name.
Q. Were concerns of the type expressed by this urologist part of the factors that were considered in deciding whether or not to move to an ASP-based methodology?
MR. COCO: Objection.
A. I didn't make the decision, so I don't know how things were weighted. Are you asking --
Q. I'm asking, was it one of the factors that was considered?
MR. COCO: Objection.
A. I don't know what was considered, since I didn't make the decision.
Q. Let me phrase it another way.
A. Okay.
Q. Was this communication part of what you discussed with others at the company as potentially relevant to the determination as to whether or not to move to ASP?
A. You mean this communication or any communication -- like MASCO or anything?
Q. Both.

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A. Sure.
MR. MANGI: Let's mark this document Exhibit Cook 010.
(Exhibit Cook 010, Document Bates-numbered BCBSMA-AWP-10609 - 10610, marked for identification.)
Q. Would you take a look at that document, please, and let me know when you're ready.
(Witness reviews document.)
A. Okay.
Q. Now, what is the provider financial strategy workgroup in general?
A. It's a corporate committee with folks from all different departments who sit and talk about various financial issues that affect our provider payments.
Q. Do you ever participate in that work group's meetings?
A. I may have on one or two occasions sat in for one of my bosses, but I'm not a standing member of this committee.
Q. Now, if you look at the second entry for

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universal fee schedule?
A. Correct. Okay.
Q. The second entry, "Sales (Steve Booma) suggested that we would benefit from having strategic negotiations by entity and geographic location because that way we would not be leaving money on the table."
Do you see that?
A. I see that.
Q. Do you have an understanding as to what the issue is that Mr. Booma is referring to there?
A. No, I don't.
Q. Okay. Do you know whether or not there has been any strategic negotiation with specific providers since this meeting was held in April of 2004?
A. No, I don't.
Q. Is it your understanding that there has been no provider-specific negotiation?
MR. COCO: Objection.
A. I don't know anything about -- I don't really get involved with provider negotiations, so

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I don't know what they've been -- what they specifically have been doing. Let's put it this way: My role is very limited in any kind of provider negotiations, but I don't know direct knowledge of that.
Q. You said earlier one of your responsibilities is supporting provider contracting, right?
A. That's correct.
Q. What do you mean by that?
A. When -- provider contract is negotiating with a hospital. That's usually what it would be, a hospital entity. Sometimes they -- or maybe even like a large group, they might ask me to participate in a small portion of the discussions that are relevant around clinical issues.
Q. Okay.
A. So if there was something clinical like performance metric on the table or there was a clinical issue the group brought in, the contracting team might ask me to come in and discuss that issue.

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Q. Okay. So is your only involvement with the provider contracting in relation to dealing with clinical issues?
A. Pretty much so.
Q. Do you ever get involved in reimbursement- related issues?
MR. COCO: Objection.
A. Reimbursement as it might relate to a clinical issue?
Q. Well, do you ever get involved in discussions as to the amount of reimbursement?
A. I always hear about the amount of reimbursement, but I mean, somebody might -- a clinical group or let's say a hospital might say we don't think -- we think that this procedure or this device should be covered outside the DRG. I mean, I would be involved --
Q. Well, let me focus you on physician practices.
A. Okay.
Q. Do you ever get involved in discussions with physician practices as to the amount of

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reimbursement that they received?
A. The only time I get involved -- not on a practice level per se, no.
Q. And was it your testimony that you have no understanding as to what Mr. Booma is referring to here when he talks about not leaving money on the table?
MR. COCO: Objection.
A. I didn't hear this conversation, so I'm not going to speculate about what he was talking about.
Q. Well, my question is, do you understand what he's talking about, regardless of whether you were involved in the discussion or not?
MR. COCO: Objection.
A. Frankly, no, I don't know what he was talking about.
Q. Okay.
A. I know what it means to leave money on the table, but I don't know what he meant in that situation.
MR. MANGI: Let's take just a minute or

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two, and I'll try and dig up what else we have left to get you out in time.
THE WITNESS: Thank you. I appreciate that.
(Recess taken.)
Q. Now, do you know Lisa Gorman?
A. Yes, I do.
Q. Okay. What is your understanding of Ms. Gorman's role at the company?
A. She's a provider relations manager.
Q. Did she deal with a particular provider or particular region?
A. I'm sure she does, but I'll be darned -- I'm trying to think if she's in charge of the south. Her job's changed over the year, so I'm not exactly sure. I think she's in the South.
Q. How long has she been with the company?
A. I don't know.
Q. How long are you aware of her having been at the company?
A. Since the 2000s.
Q. And she works for Steve Fox; is that

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correct?
A. That would be correct.
Q. Are you familiar with a group called Dyckman & Associates?
A. Pardon?
Q. Are you familiar with a group called Dyckman & Associates?
A. Doesn't sound familiar.
Q. Do you have any familiarity with a survey performed by Dyckman & Associates for MedPac?
A. Not offhand.
Q. Do you know whether or not BC/BS of Massachusetts participated in that survey?
A. Not offhand.
MR. MANGI: Nothing further.
MR. COCO: I just have one question, or maybe two.

CROSS EXAMINATION
BY MR. COCO:
Q. If you recalled earlier you were asked a

serious of questions concerning the P&T committee?
A. Correct.
Q. During your tenure on the P&T committee, did that committee discuss physician- administered drugs, or make recommendations with respect to physician-administered drugs?
MR. MANGI: Objection to the form, leading.
A. The P&T committee works on formulary, and the formulary is for drugs that are -- can be purchased in pharmacies, outpatient pharmacy benefit.
Q. Would that include physician-administered drugs or --
A. No.
Q. It would not?
A. No. They might occasionally look at a medical policy about that, but they would not discuss those drugs. They wouldn't be discussing those drugs.
MR. COCO: Okay. That's all.
MR. NOTARGIACOMO: Before we go off the

record I just want to clearly designate Exhibit Cook 007 as highly confidential under the protective order. The exhibit that was used is not Bates stamped and does not have that designation I just want to make sure on the record that it is designated as such.
MR. MANGI: Anything else? Okay. Off the record.
(Whereupon the deposition was concluded at 3:45 p.m.)

_____
JAN L. COOK, M.D.

Subscribed and sworn to and before me this _____ day of _____, 20____.

_____
Notary Public

United States District Court
For the District of Massachusetts
I, Jessica L. Williamson, Registered, Merit Reporter, Certified Realtime Reporter and Notary Public in and for the Commonwealth of Massachusetts, do hereby certify that JAN L. COOK, M.D., the witness whose deposition is hereinbefore set forth, was duly sworn by me and that such deposition is a true record of the testimony given by the witness.
I further certify that I am neither related to or employed by any of the parties in or counsel to this action, nor am I financially interested in the outcome of this action.
In witness whereof, I have hereunto set my hand and seal this 7th day of March, 2006.
Jessica L. Williamson, RMR, RPR, CRR
Notary Public, CSR No. 138795
My commission expires: 12/18/2009